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ORIGINAL ARTICLES.

BLOOD PRESSURE.

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THE following is presented as the digest of extensive reading on this subject and of considerable experience:

In a former preliminary talk we learned *that* intelligent consideration of this subject began less than twenty years ago with the Italian, Riva-Rocei (1896).

That it is defined as arterial pressure or tension of the blood in its containing vessels, and is of three forms, systolic, diastolic and pulse pressure.

That instruments for ascertaining blood pressure require on the part of the operator palpation or auscultation over the course of the vessel, the phenomena in the latter case (thump, murmur, thump and duller sound) depend on the physics of fluids propelled by a pump through tubes.

That each pulsation is not recorded as in the case of the sphygmograph.

That the base factors in blood pressure are: Cardiac strength, peripheral resistance in the vessels, elasticity of the walls and volume of blood, of which the first two are more important.

That *systolic* pressure means intraventicular pressure.

That *diastolic* pressure means peripheral resistance, and shows by the variation from the systolic the heart strength and the condition of the arterioles.

That *pulse* pressure is "the head of flow" or velocity of the current, and should show a range of 30 or 40 mm. Brunton says: "The pulse pressure depends on the pulse rate—with slow pulse and low diastolic pressure, pulse pressure is increased—the stronger the heart, the longer the interval between systoles and the larger the pulse pressure; therefore, low systolic pressure and large pulse pressure with strong heart means dilated vessels; low systolic pressure and eslight pulse pressure mean weak heart and probably dilated vessels; low systolic pressure and slight diastolic mean compensation AND DANGER; if systolic and diastolic readings approach you have weak heart and failing circulation with impending death." Hence pulse pressure is the most important element in blood pressure work and will become routine.

That the amount of blood delivered to an organ equals the pulse pressure in millimeters multiplied by the pulse rate per minute.

That the normal readings are:

	Children.	Early Adults.	After 40 Years.
Systolic,	70 to 100	100 to 130	120 to 145
Diastolic,		25 to 40 lower.	25 to 40 lower.

That there are physiological variations in the readings on account of position of the cuff, the position of the patient, nearness to meal time, the depth of inspiration, exercise, sleep, altitude above sea level, atmospheric changes, speed of your work in taking the pressure.

So far this question is one of special interest because it leads to better understanding of our wonderful human machine in normal working order.

We also studied in the preliminary survey *blood pressure* in anæsthesia, and found *that* under *ether* it was increased because of irritation of mucous membranes and muscular activity in second stage; *that* under *nitrous oxide* it was increased because of the asphyxia; *that* under *chloroform* it was decreased, and remains low except in pregnancy; *that* if shock or collapse is imminent the blood pressure falls before any other signs are manifest, hence the value of five minute readings. We can easily correct the anæsthetic procedure or stop entirely, suspend the operation and use salines; *that* pressure readings should be taken routinely before, during and after operation (the patient should not be moved from the table in face of falling or low pressure); *that* blood pressure is the best estimate of shock.

We pass now to consider blood pressure readings in abnormal or diseased conditions. When not due to factors above enumerated, increased peripheral resistance (blood pressure) depends on the sphlanchnics and follows increasing stress of modern business and social life, with various food irregularities. In the very beginning these cases show spastic condition of the arterial system with no organic changes, very generally due to toxæmia from lack of good hygiene. Routine blood pressure examinations will detect such changes at the onset and determine prophylactic treatment against more serious development. You can readily see that hypertension is not a

disease but a symptom that leads to closer study of the real pathology, and without which we would grope in ignorance until unmanageable physical changes appeared. I here enumerate some conditions that may be discovered by proper examination after a "pointer" given by a reading of hypertension:

Angiosclerosis—in reality chronic interstitial nephritis.

Angina pectoris.

Arteriosclerosis (associated with high blood pressure when sclerosis affects the sphlanchnics and aorta above the diaphragm)—pure senile arteriosclerosis has no associated hypertension. *Cerebral arterial degeneration* cannot be absolutely diagnosed from the general blood pressure, but it must be always suspected from superficial sclerosis and moderate elevation of blood pressure.

Auto-intoxication; drug action; epilepsy in idiopatic form the pressure falls with the attack); *exophthalmic goitre; eye diseases* (spasm of retinal vessels, cataract, glaucoma, retinal hæmorrhage and degenerations as in nephritis); *gout; heart disease* (*e. g.,* hypertrophy, valvular errors, inflammations); *intracranial tension; nephritis* (interstitial or parenchymatous); *eclampsia; plumbism,* etc., etc.

Take now the opposite blood pressure reading—hypotension. By this is meant a systolic reading of 100 mm. or lower in the adult. The significance of this is just as great as that of hypertension in diagnosis, prognosis and treatment. The word "asthenia" best expresses the general type, but most of the cases are those of depressed vasomotor control by toxines (at least until the advanced stages). For example, *acute heart conditions* (pericarditis, etc., etc.).

Chronic malignant and wasting diseases (cancer, phthisis, pernicious anæmia).

Diseases with marked loss of fluids (cholera, dysentery, vomiting, peritonitis, etc.).

Drugs (alcohol, tobacco, aconite, nitrites, iodides, purgatives, chloral hydrate, thyroid extract, pituitary extract, etc.).

Hæmorrhage from any source.

Acute infectious diseases (diphtheria, pneumonia, rheumatism, typhoid, *scarlatina,* etc.).

a. In pneumonia, if the systolic pressure in mm. exceeds pulse rate expressed in beats per minute, the condition is good; when the opposite obtains the condition is serious. N. B.—This will explain the damage of alcoholic stimulants. In this disease the blood pressure will determine whether the condition is one of vasomotor paralysis (due to toxines) or whether cardiac failure is imminent (high pressure). In this disease also the pulse rate is most important as it indicates the true heart strength.

b. In typhoid a sudden, sharp fall of blood pressure means hæmorrhage, while sudden, sharp rise most frequently means *perforation,* because the irritation of the peritoneum indicates reflex vaso-constriction.

c. In acute infections of children a reading of 60 to 80 means stimulate to forestall collapse.

In neurological conditions (alcoholic delirium, insomnia, mania, some forms of melancholia, hysteria, paresis, neuralgia, shock, syphilis, tabes). We may compare these with gastric crises, lead colic and angina abdominalis, which are the only painful conditions in the abdomen that show high pressure.

From the foregoing we can easily see the great and growing importance of the knowledge obtained by blood pressure readings, and can also see why we dare not deny ourselves all the information thus to be secured. It is fortunate that we need not search for absolutely exact readings, down to a mm. or fraction thereof, but we are remiss if we do not get the best reading possible and use it as a pointer toward more exact diagnosis and treatment. I decry its use simply because it is new or a fad, but insist that it is a necessary, legitimate addition to our working methods.

The medical directors of our insurance companies are requiring reports of blood pressure tests in the majority of applicants for insurance contracts. I quote: "The statistics on 1,247 cases at all ages in which a blood pressure reading of 150 mm. (Hg.) or more was found, show a mortality of 2½ times greater than the general average of the company in the same period. In 891 of these there was no other recorded impairment in the application. These statistics demonstrate that the use of the sphygmomanometer will be of equal value to the practitioner in general practice, and that no physician should be without this valuable aid in diagnosis."

This emphasizes the fact that many times the blood pressure is a warning or danger signal that cannot be disregarded safely by the company or the applicant. Such an authority as Janeway says: "That a blood pressure reading of 145 mm. before middle life or of more than 160 mm. after that must be considered abnormal." As you will all be called on from time to time to make insurance examinations, I should like to advise, as follows, in blood pressure work:

a. Place the cuff (5 or 6 inches wide) on the arm at the level of the heart.

b. Have patient in sitting posture, quiet and free from excitement, tension or mental strain.

c. Make actual determination rapidly.

d. Always secure and record both systolic and diastolic readings accurately.

e. In doubtful cases use functional test of myocardium by regulated amount of exercise with blood pressure readings, such as walking rapidly across rooms or up and down stairs.

a. Blood pressure and pulse rate are both elevated by exercise; on ceasing, both return to previous level, the pulse rate a little sooner.

b. In myocardial troubles these both go up on

exercise, on ceasing both return to previous level, the blood pressure quite rapidly and the pulse very slowly.

THE IMPORTANCE OF URINARY EXAMINATION.

BY J. G. KEISER, M. D., COLUMBUS, O.

THE title of this paper may indicate that the subject is almost too general to bring before you, but it is the best title I can choose to bring to your notice a few little, actual experiences which I have had and the conclusions I have drawn from them, and also the lessons I have learned. I am very much of the opinion that it is the actual experiences which we undergo that form the lasting impressions upon our minds, and that they do us more real good than the reading of page upon page of medical literature as to what diseases are *typically*. So with your kind permission I wish to recite to you three cases with which I have come in contact, and to tell you the impressions which they have made upon me.

Case number one happened while undergoing a hospital experience and, to me, is a very interesting one. A woman about 40 was transferred from another hospital to female tuberculosis to ward L, upon which bed patients are received. She was not under my direct supervision upon entrance, but by a change of service two days after her arrival fell under my care. At this time I looked her over, the history already having been taken and chest and sputum examinations having pronounced her apparently negative to tuberculosis, to which conclusion I also came. But she presented other symptoms which made her a bed patient. She seemed in fair shape, physically, but had a form of mild delirium, not a prostrate or semi-comatose condition, but more the symptoms of an active delirium. Questions asked her would fix her attention, but she was unable to intelligently answer, and her condition was such that a nurse had to be constantly at her bedside to keep her in bed.

She did not fight but muttered and tossed and saw all manner of things about her. Looking up her urinary chart same was found to be negative, and having just come off the ward of nervous disease I figured we had a case of insanity to deal with. So medicine was given, as her symptoms seemed to indicate, a restraining sheet was ordered and books resorted to to endeavor to make the correct diagnosis. The next morning her condition was the same, no better at least, and a satisfactory diagnosis not having been made, she was kept under further observation. In the afternoon the delirium seemed a little more active and the urinary card was looked up again to see that wrong one had not been pulled. The same one was found. So, perforce, back to the books to delve some more. About this time I got to thinking on it and concluded that it wouldn't be a bad idea to make a urinary examination myself, which being done, I found a urine loaded with albumen and containing great numbers of casts, mostly granular. Measures for acute uræmia were resorted to but the woman died within a few hours. She at no time had any convulsive symptoms, nor that condition known as a uræmic chill. In explanation of the urinary chart will say that the urine examinations of all entrants upon tuberculosis were made by two students acting as externes, and it has always been my impression that in this particular case the urine was not examined, but instead a negative card returned.

Case number two was that of a young man approximately 23 years of age, who, while working in a cider mill, happened to slip upon an especially luscious apple, fell and struck upon the back of his head. He lay for a couple of hours in the open (this being a cold, wet fall day) apparently not seriously injured, but just recovering from his fall, and then was removed to his home and I was called. He had a mild degree of fever about 100.5°, and throat examination showed a beginning of tonsillitis, with no apparent trouble from the effects of the fall. Medicine left for trouble as found, *i. e.*, for those symptoms resulting from an acute tonsillitis, and I went away with no intimation of any particular further trouble. Therefore, was surprised, and I will confess rather shocked, when a couple of hours later I was called to the phone by the mother and urged to come quickly as Harvey was dying. I did so, and upon arrival found that Harvey was just getting over the effects of a mild convulsion. It being my duty as a physician to tell immediately just exactly what was the matter, I very learnedly expatiated to the effect that the fall was the probable cause of the convulsion, and at the time I really believed same, there being no other reasonable explanation in my only partial analysis of the case. The next morning on return found that the young man had had another very mild attack, and a specimen of urine being obtained, same was examined and found to contain a fairly large amount of albumen on the contact test, and some granular casts. Of course this cleared up the case, and measures eliminative in character having been resorted to, and the tonsillitis kept in mind along with the kidney complication, the young man soon recovered, that is, to the point where he was before the acute condition came on. Upon questioning the mother I found that years before he had had a condition of general œdema following scarlet fever, which it had taken months to relieve, the same being very unimportant bit of history to the mother at this time, but bringing much light to me. The young man, the last time I saw him, still carried about with him a damaged pair of kidneys, and in my opinion always will. However, he has, or had, no

outward manifestations of this kidney involvement.

Case number three was that of a lady about 50; three children; of a very nervous temperament, and having those symptoms which we find in this particular nervous type. Was subject to constipation, a mild gastric and intestinal dyspepsia with a great deal of gas, headaches, and about every two months would be laid up for a day or two with an acute gastric condition with liver symptoms always prominent. She also had, or at least was supposed to have, some indefinite female trouble for which, from time to time, she went to a lady physician. This case was under observation for a long period of time, the acute symptoms, whenever they arose, being amenable to treatment in a couple of days' time, but the chronic condition never thoroughly clearing up, *i. e.,* the tendency to headache, constipation and intestinal indigestion with gas. Lately an acute condition involving the stomach and liver with attendant headache was treated over a couple of days' time and benefited to the same extent as during former attacks following which the lady physician was called for treatment of the uterine condition. Shortly after this time the lady went to bed, and after three weeks' time, relief not being had, resorted to her former physician, and a truly remarkable change for the worse was noticed. She was retching and vomiting this condition having lasted for thirty-six hours; could retain nothing, and her general condition was extremely bad. She was very weak and restless, and her general decline was marked by the very dark circles under her eyes, these circles extending well down into the cheeks. Suspicions having been finally aroused, a urinary specimen was obtained, and upon examination was found to contain 4 gms. of albumen to the liter, and granular casts in profusion. History elicited the fact that she had a similar spell thirty years before, following the birth of her first child. The uræmic symptoms were alleviated for the time being and her albumen brought down to 1 gm. per liter, but finally the kidneys wore out, as it were, the urine decreased in amount with an inverse proportionate increase in albumen, and she died.

Now here are three cases which to me are of much interest, and as said before they have brought to me several very definite conclusions. First and *foremost* that as a routine in the examination of *every* case should be the *examination* of a urinary specimen. We all do this in the acute conditions, especially exanthematous in nature, but we are very prone to forget the importance of this examination when a case comes to us presenting chronic symptoms, especially when these symptoms are manifested *wholly* in other organs.

Secondly, that nephritis, unless we catch it during its acute stage, does *not* present peculiar or classic symptoms, as a rule, which would point to kidney involvement. A parenchymatous kidney which has become chronically involved may go along for months or even years presenting vague symptoms in other organs, and insidiously advance in its decay, until a uræmic condition definitely brings the kidney to our mind. The same is true of the interstitial type, only more so. The two latter cases mentioned were undoubtedly parenchymatous kidneys of long standing, yet at first showed no particular symptoms directly referable to the nephritic condition.

Third, that every case, even of incoherency, in a person should make one suspicious of kidney involvement, and that at the start the kidney should first of all either be eliminated or fixed as the guilty party.

Fourth, that every chronic case involving the liver and alimentary tract, especially those cases with symptoms of excessive formation of gas, are always to be looked upon as suspicious of kidney involvement until proven otherwise.

Fifth, that chronic recurring headaches may be due to eliminative troubles and toxic in nature, and that a urinary examination should always be made to be sure that a damaged kidney is not the cause behind the headache.

Sixth, insofar as treatment is concerned, notwithstanding the meagre importance of diagnosis, so considered, in the search for the similimum, in these particular cases. I believe that prior diagnosis is absolutely essential to the proper interpretation of symptoms in our search for the properly selected remedy, as well as in our general treatment, which means a very great deal in the final result of the case. For by the proper general treatment a great many times we are enabled to hold our patient over long enough to make our second, and sometimes even third, essay, at the properly indicated remedy, when otherwise we would not have had the chance.

These few statements hardly seem impressive enough for the gravity of these conditions when found, and the importance to us of finding them and finding them early, but if I have done nothing else I will feel satisfied if I can leave the impress upon you that the kidneys should be that of *first, last* and *always,* that the best habit in the world is that of first of all either definitely fixing the kidney as the primary cause of the trouble or of eliminating it, however, keeping set in a corner of our mind the fact that at any time the kidney may become acutely involved.

Boericke & Tafel report that the new vehicles for the administration of homœopathic medicines—Diskettes and Blankettes—are being very favorably received by the profession. Samples will be sent on request.

THOUGHTS PERTAINING TO THE THERAPEUTICS OF INFECTIOUS DISEASES.*

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FELLOW Members of This Society: As time advances I am becoming more and more impressed with the necessity of a broad and comprehensive study of the principles underlying therapeutics.

Show me the principle that underlies the correct treatment of rheumatism and I will show you the principle that underlies the treatment of every infectious and contagious disease, and indirectly of every disease. If there be a law in therapeutics we shall find it as operative under the microscope, as at the bedside. By observing the physiological and pathological functionings of the body tissues, we are able in most cases to explain observed phenomena, thereby opening to our vision a new field, the pathological significance of symptoms, a field of vast importance as yet scarcely touched upon.

Let us then with minds thoroughly receptive to the truth, from whatever source it may come, attempt to gather together some apparently well established facts pertaining to therapeutics. Sajous has said: "The reason why we do not better understand therapeutics is because we do not utilize the knowledge at our command." In this we opine he spake more wisely than he thought.

I shall not attempt to go deeply into the investigations of Ehrlich and Metchnikoff, except to say that Sajous in his work upon the internal secretions has apparently harmonized the finding of these two investigators, so that we will turn directly to Sajous' work.

In Vol. II., page 1,023, Internal Secretions, 1914 edition, he says: "The thermogenic center is located in the partition between the two lobes of the pituitary body, as such it is the governing center of the adrenals, its nerve path to these organs being as follows: From the test organ to the posterior lobe of the pituitary, thence upward to the tuber cinereum, along this structure to the pons and bulb, and down the spinal cord to the first, second and third dorsal nerves, thence to the sympathetic nerves, in which it reaches the suprarenal plexus and through it the adrenals."

Here we have Sajous' conception of the machinery. How does it work?

Turning now to pages 1,131 and 1,132 of the same volume we read: "The test organ governs the secretory activity of the adrenals and of the thyroids and para-thyroids through the intermediary of a center located in the posterior pituitary body, the adreno-thyroid center, and when drugs, toxins, waste products, etc., provoke a defensive reaction of the test organ, it is by exciting simultaneously the adrenal and thyroid apparatus, through the adreno-thyroid center, that it (the test organ) increases the proportion of adrenoxydase and thyroidase in the blood. Adrenoxydase by hastening metabolism provokes leucocytosis (an increase of phagocytes) and an increase of nucleo-proteid and trypsin and combines with these bodies to form the bacteriolytic and antitoxic constituents of the blood and its phagocytes, while thyroidase sensitizes (as opsonin) the pathogenic germs and substances to render them vulnerable to the defensive constituents. Thus it follows that the adreno-thyroid center under the dependence of the test organ is the center through which all the body's auto-immunizing functions are performed." That we may get this clearly in mind we will attempt to follow these phenomena as they take place in the well known condition of diphtheria. Immediately upon the entrance of the bacilli into the tissues, and the beginning formation of toxins, an impression is transmitted to the test organ in the pituitary body, thence to the adrenal system, resulting in increased functional activity, which means increased oxygen carrying power of the blood, increased temperature and increased leucocytosis and phagocytosis, depending upon increased adrenoxydase and thyroidase. In other words, disease is the phenomena arising from the efforts of the system to protect itself against some enemy to the tissues. A failure of the system to react means either immunity or death. Referring now to the relation of toxins and drugs Sajous further says: "Another feature upon which some stress must be laid is that the physiological action of the antitoxins (as I interpret it) is identical with that provoked by various drugs, each of which likewise introduces its own array of evidence" (he does not say array of similar symptoms), but he does say: "If, therefore, we grant life-saving properties to antitoxin (which is undoubtedly the case so far as diphtheria antitoxin is concerned), we must concede the same value to drugs which are capable of evoking in the blood the formation of the same substances, *i. e.*, auto-antitoxin." (Vol. II., page 1,184.) Now if these phenomena comprehend all that is necessary, in a given case, our therapeutic rule will be, choose such a remedy as will properly stimulate the adrenal system, thereby causing the proper formation of auto-antitoxin, and we will have accomplshed all that any therapeutic agent aside from antitoxin itself can do. In harmony with this rule, Sajous recommends in the treatment of diphtheria the Biniodide of mercury to stimulate the formation of auto-antitoxin and antitoxin.

It is now an established fact that many drugs, among which are to be mentioned the so-called alteratives of the dominant school, have the power of markedly stimulating the adrenal sys-

*Portion of a paper read before the Cleveland Homœopathic Medical Society, the evening of Jan. 20th, 1915.

tem. It is also a well known fact that a marked degree of immunity to many drugs may be established, among which may be mentioned ricin, tobacco, arsenic, quinine, opium and morphine, the snake poisons and others. Thus, again, we see that the relation of drugs to the adrenal system is practically the same as the relation of toxins. But Sajous' rule is not sufficiently comprehensive, as at times the opsonic index may be normal phagocytosis may take place apparently properly, but still the case may progress to an unfavorable issue. Again he fails to take into consideration the formation and action of other ferments, as he also fails to give any consideration to personal idiosyncrasy.

Here let us introduce the work of another investigator, the German physiologist Abderhaldin. Abderhaldin evidently fully recognized the work of Sajous, but has gone one step farther in his work upon "How the Organism Diagnoses and Treats Its Own Ills." He claims that each organ and tissue is composed of cell structures peculiar to itself, and in order that the blood, the great circulating medium, may at all times be kept in a perfectly homogenous condition, there is secreted by the cells of each tissue a ferment capable of digesting or decomposing the waste products of the tissue. If now for any reason waste cell elements appear in the circulation in an improperly prepared form, there immediately also appears in the circulation the ferment necessary to care for these cell products. Abderhaldin claims that by this knowledge we may diagnose certain morbid conditions before they have progressed sufficiently far to be recognized by the ordinary means of physical diagnosis.

Now applying the knowledge obtained from Abderhaldin's investigations, and reasoning along the lines of Sajous, we can, it seems to me, formulate the following therapeutic rule, which will afford us at least a working hypothesis: in a given case choose a therapeutic agent which by virtue of its power to stimulate the adrenal mechanism, will produce a reaction most similar to that produced by the toxin present, and at the same time by virtue of its selective affinity for certain cell structures stimulate the formation of special cell ferments necessary to care for tissue waste appearing in the circulation by virtue of improper cell metabolism.

We have by the foregoing added to our rule the element of selective affinitty, and still the one word that expresses the great underlying principle of drug action is REACTION.

What we still lack is the personal equation or individuality. It is a well known and established fact that two persons suffering from the same disease with, in all probability, very similar tissue changes, may manifest vastly different phenomena. Here let us introduce statements from the work of another investigator who, though he lived over one hundred years ago and lacked the modern instruments of precision, made observations which entitle him to a place among the most advanced research workers of any age. In his preface to the Organon Hahnemann says: "Cures result only from the counteraction of the vital force against some medicine chosen according to correct principle, and that curative effects are speedy and certain in proportion to the energy of the vital force of the patient." A little farther on he says: "Such a medicine is administered in simple form at long intervals, and in a dose so fine as to be just sufficient without causing pain or debility, to obliterate the natural disease through the reaction of the vital energy." (Organon, 5th American edition, page 5, preface.) Had Koch followed these directions he would have avoided his painful experience in the introduction of Tuberculin. Upon page 34 of the same volume Hahnemann, in substance, says: "The very efforts of the system to rid itself of some influence inimical to health, constitutes disease." Here we find clearly expressed the claim that REACTION is the great principle underlying all the phenomena of disease and all curative efforts.

Hahnemann gave explicit directions for the examination of the patient. To thoroughly understand the condition of any patient we must possess ourselves of all obtainable knowledge, including heredity, environment, acquired disease. diet, age, occupation, social life, habits and mental condition.

"We should ascertain the condition in health and the deviations from the previously healthy condition of the patient, felt by him, and recognized upon him by his attendants, and observed upon him by the physician; all these observable signs together represent the disease in its fullest extent, that is they constitute together the true and only conceivable form of disease." (Organon, 5th American edition, Sec. 6.)

Physiology and anthropology teach us that man more than any other animal is endowed with a highly developed nervous system, capable of receiving, transmitting and interpreting impressions. Hahnemann of all research workers is the only one who has seen fit to utilize this apparently fruitful source of information, and it is to the disgrace of the homœopathic profession that the pathological significance of symptoms is not better understood. Hahnemann believed and taught individualization and the totality of symptoms. He taught that a drug to be curative must possess the power of producing either similar or contrary symptoms, and he says: "Experience invariably proves that when a drug capable of producing symptoms similar to those present in a given case is administered, it invariably influences the system for good, providing it is given in a dose short of that capable of producing an aggravation (in other words, short of embarrassing the adrenals and other ferment

forming bodies). (Organon, 5th American edition, sections 22, 23 and 25.)

Hahnemann read a chapter from the book of nature, and with head bowed in reverence to the Almighty, proceeded to apply its truths to the relief of suffering humanity, and it is for us, his followers, to perpetuate the work he so nobly began. He was the king of observers; what he writes in reference to contagious and infectious diseases shows beyond a question of doubt that he recognized the presence and importance of a specific poison, known to-day to be bacteria and their toxins. Turning to sec. 102 of the Organon, the last part of the sec. reads: "The individuals suffering from a prevalent epidemic are apt to be affected alike, because each case arises from the same source; nevertheless, neither the totality and scope of an epidemic nor the totality of its symptomse are to be observed upon a single patient; such knowledge is only to be obtained, in a perfect manner, by observation of the affections of several patients of different bodily constitutions." Here we see that Hahnemann changes his rule from the totality of the symptoms of the patient to the totality of the symptoms of the disease, recognizing that a remedy must be chosen capable of evoking in the system a reaction similar to that produced by the toxin present. Acute rheumatic arthritis is by most authorities of the present day recognized as an infectious disease, and it is interesting to compare the treatment advised by Sajous with that worked out according to the rule of Hahnemann.

Sajous teaches that there is no known germ, no known toxin, and no known specific. He, therefore, simply advocates normal salt solution to thin the blood and chloral-hydrate to inhibit the action of the adrenal system and relieve pain. He condemns the use of the salicylates, teaching that they constrict the arterioles and lessen the supply of blood to the heart, and are not, therefore, to be used. (Internal Secretions, Vol. II., page 1,868, 1914 edition.)

The foregoing statements are rather surprising when we consider the fact that the dominant school has always claimed that in the early stages rheumatic fever may frequently be aborted by large doses of this same substance. That we may obtain a knowledge of this drug and thus be able to refute the statements of Sajous, let us attempt to review the pathogenesis of salicylic acid and the salicylates.

In the foregoing condemnation Sajous evidently overlooked what he had previously written on page 1,282 of the same volume, for there, under a study of these drugs, he writes: "Small doses (mark the word small) cause hyperconstriction of the arterioles and arrest pain by reducing the volume of blood supplied to the tissues. They stimulate the test organ and through it the adrenal mechanism, thus augmenting the auto-antitoxin in the blood. Hence the fact that, besides acting as analgesics in rheumatism and gout, *they prove curative,* since they not only decrease the volume of blood circulating in the nerves of the painful region, but they also promote catabolism and the destruction of the pathogenic elements. But large doses are dangerous, because of the effect upon the heart." (Pretty good Homœopathy.)

Ellingwood (eclectic) gives as symptoms produced by salicylic acid the following: "Trembling and muscular uncertainty; blindness, strabismus; restlessness; depressed heart's action and temperature; decrease of oxygen carrying powre of the blood; first flushing then pallor of the face; irritation of the kidneys and hæmaturia." Goss (eclectic) adds to the above: "Gangrene of the lower extremities; cystitis; obstinate constipation; coldness of the extremities; and if long continued it will produce urticaria; irritable erythematous and vesicular eruptions; *sore throat* and quiet delirium."

Hughs' Pharmacodynamics (6th edition) adds the following symptoms: Temperature raised to 101° F., and in one case of extreme dosing where 1,400 grains were given in four or five days the temperature reached 111°, with death." He also says: "It produces roaring in the ears; deafness and vertigo."

Dewey adds to the pathogenesis: "Dyspepsia; excessive accumulation of flatulence; acidity of the stomach and much belching of gas."

Boericke says: "Knees swollen and painful; worse from touch and motion; pains shifting and burning; worse at night."

Blackwood says: "Small dose stimulates the stomach, heart and respiration; large doses depress causing profuse sweat and increased acidity of the urine."

Now that we have reviewed the pathogenesis of salicylic acid let us also briefly review the symptoms of rheumatism, and see whether or not there is any relationship between the two. I gather the following symptoms from the works of Sajous, Loomis and Hare: "Chilliness, languor, flushed face, increased temperature, irritability, coated tongue, disturbed digestion, constipation, increased perspiration, pain in the joints, tonsillitis, urine diminished but increased in acidity, albuminuria, hæmoglobinuria, cystitis, erythema, urticaria, herpes, purpuric and ecchymotic spots, gangrene of the extremities, mild delirium, at times extreme high temperature and death. The red corpuscles are diminished and the white corpuscles diminished." I ask is there a single important symptom of rheumatism not covered in the pathogenesis of the acid? I, therefore, claim salicylic acid to be homœopathic to rheumatism, especially in its early stages, and as nearly specific to the toxin of the disease as any remedy. The fact that its power to abort rheumatism depends upon its early administration in

large doses makes it resemble much the relation of antitoxin to diphtheria. The early localization of the toxins of rheumatism in the non-vascular tissues in the vicinity of the joints makes it difficult to act upon them with any remedial agent; we, therefore, question the advisability of attempting to abort rheumatism with salicylic acid or the salicylates, except in the very early stages and in robust subjects. On the other hand, we believe that the best results will be obtained by choosing a remedy (in accordance with the teachings of Hahnemann and Abderhaldin) having (because of its selective affinity) a specific adaptation to the tissues involved.

THE SURGICAL TONSIL.*

BY J. A. FERREE, M. D., COLUMBUS, OHIO.

THIS term implies, not only a diseased tonsillar tissue, but of this and the surrounding tissue.

The size of the tonsil does not necessarily convict it of being diseased. It may be fairly large and be free from any diseased condition; may not disturb phonation; may not be adhered to the anterior or posterior pillars; nor does its location permit pressure on the Eustachian tube. A large tonsil that does not fulfill any one or all of these conditions can hardly be called a diseased tonsil, hence not a surgical tonsil. While a small tonsil adhered to the pillars, has pockets filled with caseous material—the products of decomposed food and secretion, the source of constant absorption of poison—is decidedly a surgical tonsil.

An imbedded tonsil whose position is high up in the tonsillar fossæ is surgical, because of its location. Owing to this high position it interferes with free drainage of the Eustachian tube, also the free movements of the pillars; or, putting it in another way, it interferes with the normal function of the pharynx and naso-pharynx. The tonsil that is adhered is surgical for like reasons. From repeated attacks of acute inflammatory processes involving the tonsillar and para-tonsillar tissue, connective tissue infiltration being a consequence, also bands of adhesions between the pillars and tonsil forming pockets whose only function seems to be one of a cess-pool; all of which not only interferes with the muscular motion of the lateral walls of the pharynx, but is a source of infection of the cervical glands. Especially is this true in children.

Another class is the cryptic tonsil. This may or may not be adherent; may or may not be imbedded; has not the adjacent connective tissue infiltration; but is equally a surgical tonsil because of the source of infection from the crypts and should be so handled.

The evidence on the question of the entrance of tuberculous germs through the tonsil is conflicting. It does not seem that this point it sufficiently determined to condemn it without a further hearing. Personally, I am rather of the opinion that it is amongst the possibilities. Then, again, all doubts have not been removed as to the question of the tonsil being a port of entry for the etiological factors of rheumatism. Clinically, there seems little doubt. The men armed with pipette and beaker are not yet agreed. So we must wait their decision. Meanwhile the laymen furnish the battleground.

There are two important indications for the removal of the tonsil: First, to remove the foci of infection; second, to increase or restore the efficiency of the respiratory, phonatory and the articulatory organs. The operation that fails to accomplish this is more or less a failure. The contention that the voice may be altered is not without some foundation. At least, let us pause a moment for its consideration. One school of laryngologists maintain that nothing but ultimate good to the voice can result from the removal of a surgical tonsil. Another school that it never impairs the voice. While another, that in the adult there is a risk to the voice, even to the extent that tonsils should not be removed in singers. In all cases the speaking voice is undoubtedly improved. It may take time for the individual to relearn the complete use of the muscles that have been liberated by the removal of the tonsil. Now, note, please, what the evidence seems to show in the matter of the singing voice. There is a risk that the patient may not succeed in acquiring the instinctive control of these muscles so sompletely as to give him the peculiar "tone" which he may have previously prized. Persons who are only commencing the study of singing can safely be advised to have the tonsils removed if such a step is indicated; but those who already possess a trained voice must be told of the possible risk, and that they will require renewed study and practice, although they will certainly in the end acquire a stronger and better voice if not one of precisely the same tone.

The indications for the removal of a tonsil, therefore, would be based on a number of conditions: Whether it obstructs and hinders phonation and articulation; whether it is diseased and by absorption causes systemic phenomena; repeated attacks of tonsillitis or quinsy, irrespective of cause, are always an indication for their removal. On the other hand, constitutional conditions may cause involvement of the tonsil, and without directing treatment towards relief of this underlying condition; this constitutional tendency to inflammatory condition of the tonsil and peri-tonsillar tissue would not be relieved by the removal of the tonsil. The patient would

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*Read before the Southeastern Ohio Homœopathic Medical Society, Columbus, Ohio, Jan. 28. 1915.

not have an attack of tonsillitis after its removal, but in these cases the lymphatic ring around the tonsil and lateral walls of the pharynx would show the same inflammatory condition after the removal of the tonsil, unless the constitutional cause is removed.

The age of the patient is an important factor in the diagnosis of a surgical tonsil. It is certainly in accordance with facts that he who hesitates to remove a tonsil in a child errs on the safe side. I mean that more discrimination is required because this organ is yet a physiological one and has a function to perform. If it can be condemned to be so diseased that its protective powers are annulled then it becomes a surgical tonsil. This is not always an easy matter to determine. After a certain age the tonsil should atrophy. If it fails to do so, there is some pathological condition of the tonsil or surrounding tissue has supervened. The structure having ceased its physiological function, it becomes a pathological tissue. The irritation caused by the adhesions, pockets back of the tonsil, or cryptic involvement, keeps up a constant numerical increase of tonsillar structure. All of these pathological conditions may be complicated, as stated above, by an underlying systemic condition, so that the disposal of the pathological tonsil may not relieve the patient of his sore throat. So that, in view of this, it is important to determine whether the involvement of the tonsil is a local or constitutional one or both.

Now, as to the question of removal of a tonsil in the presence of tuberculosis, I believe the following statements are potent: In active tuberculous process, interference with the tonsil is dangerous. The opening up of the lymphatics and the laceration of the tissues of the throat invite a local infection, if not present, after the operation. Then, if the local process is purely local, removal of the tonsil might cause a systemic infection. If the infection has come through the tonsil and the individual is already infected, its removal would not be curative. However, if the process is arrested and for a time latent and no tubercles present in the sputum, then the tonsil might be removed.

Finally, outside of a very few exceptions, the operation for a surgical tonsil is a tonsillectomy. What say you?

Flour.

The use of bleaching flour is not injurious to health, and, although nitrite is present, the amount is too small to cause the formation of methmoglobin or the replacement of normal oxylemoglobin. Administration of nitrate of doses much greater than are ever present in flour causes no pathological condition in animals.—*Frank L. Haley.*

TUBERCULOSIS OF THE HIP IN A CHILD.

BY JOSIE ROGERS, M. D., DAYTONA, FLORIDA.

THIS is the simple record of a case illustrating the need of sturdier parentage. It is only one of the many that we frequently see.

The patient is a girl of eight years.

Family history shows that the paternal great-grandfather died of tuberculosis; the grandmother was sent south to live on account of the condition of her lungs. The father is a typical Phos. patient, subject to colds.

On the mother's side, an aunt died of acute tuberculosis.

The little patient had a severe struggle over the diet question during the first seven months of her life. She was then under allopathic treatment.

When the teeth came the digestion improved.

Rachitic symptoms began to appear—prominent abdomen, narrow chest, head sweating, bending of the ribs, restlessness at night. Until the third year, convulsions occurred whenever the temperature ran above 103°, which it frequently did, due to indiscretions in diet.

With careful watching and the frequent use of homœopathic remedies, as Calc. phos., Kali phos., Phosphorus, the child grew steadily stronger. Was tall, thin, excitable, always running instead of walking and stumbled and fell a great deal.

During the spring of the fourth year, with the terror of convulsions fading away, the mother noticed that the child limped slightly—more especially at night. On examination there was found tenderness over the right hip, some pain, referred to the knee joint, the gluteal fold was partially effaced. There was flattening of the gluteal region, restricted motion, flexed thigh, eversion of the foot and when the knee was brought down while lying there was lordosis.

Since the lameness was noticed early she was put to bed without extension or immobilization of the joint—and was kept there for ten weeks with a nurse in attendance.

Beef juice, milk and eggs were given as tolerated. Open air treatment and oil rubs were given.

At the end of the ten weeks she was gradually allowed to resume light exercise. No further trouble has been noticed in that hip.

During the next spring the same trouble developed in the left hip and the same line of treatment was adopted for six weeks with no return of the trouble to date.

The next spring she contracted a slight cold and a persistent loose cough developed. It did not give way to the apparently indicated remedies—Hepar sulph., Phos., etc. Finally Tuberculinum 200th was given and the cough was gone in two days and the slight congestion had cleared up.

Every spring, when the resistance is lowered, the tubercular tendency rears its ugly head.

How are children to have their rightful heritage of good health when they are born with diminished resistance to certain infections?

For years to come there will be a constant fight in the body of this child and unless a constant watch is kept that the powers of resistance are not weakened we shall find that in some of the skirmishes the tuberculosis forces will win.

The subject of eugenics is ever before the public eye and it should also be dinned into the public ear until the public mind has become fully conscious of the fact that the rights of the individual as well as the health of the nation are being sacrificed because of ignorance.

NOTES FROM THE COLLEGE OF HOMŒOPATHIC MEDICINE OF OHIO STATE UNIVERSITY.

BY ALBERT E. HINSDALE, M. D.

THE College Hospital, which is known as the University Homœopathic Hospital, has been in operation now for over four months and a considerable variety of clinical material has been admitted. The surgical clinics have been receiving a plentiful share of material, and, at least, one major operaton is an average day's work for these departments. The eye, ear, nose and throat clinic is well patronized, and from fifteen to twenty patients are frequently taken care of in an afternoon; several of these cases require operative interference. The clinic for the past week comprised, among other things, a mastoid operation, a cataract extraction and several submucus resections. There is no reason why a student who desires to take up with this specialty cannot have enough actual experience during his junior and senior years to qualify him to at once enter upon this specialty soon after graduation.

An X-ray instrument—said to be the best that money can buy—has been purchased for the college from the general university funds. This machine is now being installed and will be operated by one who is thoroughly conversant with the special technique necessary for its successful operation.

The number of nurses in the hospital now numbers five, and the university is fitting up a special house near the hosiptal to be used as a nurse's home.

The newly organized pathogenetic laboratory to be used for purposes of instruction in materia medica is being rapidly fitted up, and by next year definite courses of instruction will be given in this laboratory.

A drug proving, conducted by the Department of Materia Medica, is now being conducted, and interesting results are being obtained. A resume of the proving will be issued as soon as the symptoms obtained by the provers can be checked up.

Several obstetrical cases have recently been received at the hospital, and this necessary part of the clinical instruction promises to be well provided for. Students already have had the opportunity of witnessing several such cases.

Doctors Carpenter and Keyser, both of Columbus, have been added to the clinical staff of instructors. Dr. Carpenter is giving a course of lectures on nervous diseases, and Dr. Keyser lectures on diseases of children.

BY W. A. HUMPHREY, M. D.

The Department of Gynæcology has exceeded all expectations in the amount of material and the variety of cases presented. Not since the first case came, a short time after the opening of the hospital, has there been any lack of material. Upon several occasions it has been necessary to hold extra clinics in order that all of the material should be used. Material has come freely from Columbus, but by no means has all of it come from this source. Several of the outside cities and towns are contributing to this clinic. Dr. Caldwell, of Jackson, sent in a most interesting case of carcinoma of the uterus, which was beyond the operable stage, but which gave an opportunity to demonstrate the action of Radium in such cases.

This case was treated by means of a tube of Radium of low activity, which was very kindly loaned by Dr. Chas. Ireland, of Columbus. The treatment continued over a period of several weeks. The Radium was applied for several hours upon alternate days at first; later on, not so frequently. The benefit at first was marked; the hœmorrhage ceased, the discharge was much less. There was a standstill apparently in the disease. After several weeks the growth became very active with the return of active hæmorrhage. It is doubtful whether the patient was any better at the end of the time than if the treatment had not been pursued. The course of the disease in this case tallies very closely with that of most cases treated by Radium; that is, while there is a temporary arrest of growth subsequently there is marked advancement, probably surpassing that which would have gone on had no interruption taken place.

The abdominal work of the clinic has been universally successful as to mortality, and has been of such variety as to be of great benefit for teaching purposes. The obstetric ward has been occupied by maternity cases continuously since December 20th. Material is abundant. Our seniors are getting the necessary cases for their requirement.

THE USE OF QUININE AND OTHER DRUGS IN THE TREATMENT OF MALARIAL FEVER.

BY ALBERT EUCLID HINSDALE, M. D., COLUMBUS, OHIO.

ALL intermittent or periodical fever is not malarial. Certain septic fevers are characterized by chill, fever and sweat; tuberculosis, for example, is apt to be associated with sepsis, so that there is diurnal periodicity of the fever, at least, and oftentimes of sweat and chills. To these septic fevers Quinine or most of the drugs which are mentioned in the texts as being useful in intermittent fevers does not apply.

The diagnostic verification of "malaria" is the finding of the plasmodia in the blood cells. These organisms go through an evolutionary change of development, and, finally in 24, 48 hours, or a longer cycle, disintegrate and give off a part of themselves that is still viable, and that is to form the new, fully developed organism, again to repeat and be associated with the constitutional effects of chill, fever, etc.

One of the fundamentals of Hahnemann's Organon is to find and remove the cause of disease. Upon this Hahnemann laid great stress, although the teaching of the homœopathic extremists is that if the symptoms be treated, the cause must discontinue, which sometimes is the case, sometimes not. Why not then, since we know the real cause to be the plasmodium, remove or inhibit its growth at once, if we can do so, pleasantly, safely and with celerity.

The removing of the cause of malaria by the use of Quinine is based upon the fact that Quinine acts as a parasiticide to the plasmodium much in the same way that tincture of Staphysagria acts as a parasiticide towards the pediculus pubes. The removing of the cause of malaria by a parasiticide is not homœopathic, that is, if we believe the agency used acts in accordance with the rule of similars, although there is some similarity between Quinine and the periodicity of intermittent fevers.

If it is not against the homœopathic principle to remove the cause of disease, when such can be done, the indicated treatment for a sliver under the thumb nail is to pull out the sliver first, and any symptoms remaining after this has been done may be removed by the indicated remedy. Likewise, it is not contrary to the teachings of Hahnemann to dispel worms in the intestinal tract, which are practically foreign bodies, by some agent which will act as a parasiticide against these offenders. After the cause is removed, be it either in a case of malarial fever, intestinal worms or slivers in the skin, the case is one for symptomatic treatment, *i. e.*, treatment in the strictly homœopathic sense.

It should be stated here that in many diseases it is impossible to remove the cause, either because it is unknown, or because of certain mechanical or chemical impossibilities involved. In such cases it goes without saying that the treatment here consists in the administration of the indicated homœopathic remedy, and nothing will be better than this.

One more illustration: No one would sit complacently and allow a mosquito to bore his probosis through the cutaneous covering of his skull without making some effort to destroy the source of his unpleasantness. The slap of the hand which kills the mosquito is exactly analagous to the action of the Quinine which kills the bug which is gnawing at the vitals of one afflicted with malarial fever.

To return to malarial fever: So soon as the chill, fever and sweat is over, a new "crop" of organisms are beginning to develop, then is the time to "hit" them by the Quinine. Quinine will do no good unless it is administered in the right doses at the right time. Too much importance cannot be placed upon this fact. The right dose is usually from 3 to 5 grains, and the time to give it is at the time of the chill, or better yet, a short time before the next chill is to take place. If this direction as to the use of the drug is not followed, little or no improvement in the case will be obtained. Quinine and all "bark products" are absorbed quite promptly into the blood, and if the Quinine comes in contact with spores of the parasites when they are at the vulnerable state, it will inhibit their full development and prevent the next paroxysm. They are not vulnerable in their advanced stage, but early, after the corpuscle which has contained them opens up and liberates them in the free blood stream this takes place about the time of the chill. I have stopped the most severe cases by studying the phenomena of development by giving Quinine, usually but for one time, sometimes to repeat at the close of the next period.

Now, when in the treatment of malarial fever do such drugs as Gelsemium, Ipecac, Nux vomica, Eupatorium and Natrum muriaticum come in? These remedies are very useful ones, and there is no doubt as to their usefulness, provided they are given at the right time and when indicated. After the chills are "broken up" patients frequently need a remedy to cure them of the effects of the poisoning they have endured. It is in such instances that these remedies do their most good. Suppose a person to have been poisoned by Arsenic. The first and only legitimate treatment would consist in giving the chemical antidote, which is usually some form of iron, and afterwards, should any such symptoms as gastric irritability, nausea, restlessness, etc., appear, these symptoms should be combatted and removed by the indicated remedy. Quinine bears the same relation to acute cases of malarial fever as does iron to acute arsenic poisoning; and such remedies as Natrum muriaticum, Nux vomica, etc., bear the same relation-

ship to malarial poisoning as would the indicated remedy to the after-effects of arsenic poisoning.

To recapitulate:

(1) Quinine is the remedy for acute cases of malarial fever, and should be given in doses of from 5 to 10 grains.

(2) The remedy is best given at the time of the chill or just previous to it.

(3) Such remedies as Natrum muriaticum, Gelsemium, Nux vomica, Eupatorium, Ipecac, etc., bear no relationship to the acute manifestations of malarial fever but are curative for the effects of absorption of the toxines which the plasmodia undoubtedly excrete; in other words, they are indicated in whatever symptoms may remain—usually in chronic cases—after the plasmodium has first been destroyed by Quinine.

TYPES OF COMMON CARDIAC LESIONS.*

BY F. B. GROSVENOR, M. A., M. D., COLLEGE OF MEDICINE, OHIO HOMŒOPATHIC STATE UNIVERSITY.

AS a teacher of pathology I have been perfectly free to teach cardiac lesions as they appear, and can be demonstrated at post-mortem. As a teacher of diagnosis I find myself constrained by authorities who write our texts and by custom to teach diseases of the heart in a rather hit and miss manner, usually taking as a subject head some prominent symptom of the heart rather than a definite disease of the heart. Stereotyped clinical classification and the so-called nosogony of disease has hardly kept pace with the advances made in our diagnostic knowledge by means of the microscope and test-tube.

I once asked a student to name one of the most common diseases of the heart; when he hesitated I prompted him by mentioning mitral regurgitation. "But, Doctor," said the student, "that is not a disease of the heart, it is only a symptom." I paused a moment and answered, "You are right." Yet I was following the text and had to consider that leak as a subject head and not merely as a symptom. I must teach the symptom and then explain its various causes at length. It appears more logical and is easier for the student to consider the basic pathology and then describe its various manifestations and symptoms.

In doing post-mortems I classify hearts according to their pathology; I could do no other way. In the class room I attempt to make the student see in his imagination how the diseased heart would look if he actually were holding it in his hand, and what other changes associated with this disease we would find in our imaginary cadaver. In order, for instance, to get from the text a good picture of a sclerotic heart, the student must search through the subjects of myocarditis, endocarditis, mitral regurgitation, mitral stenosis, aortic regurgitation, aortic stenosis, cardiac degenerations, angina pectoris, arteriosclerosis and nephritis, and by the time he has pursued all these subject heads he has forgotten what he started out to look up.

As in drug prescribing, we must get the *totality of symptoms,* as in diagnosing a heart we must take into consideration all the symptoms, both cardiac and extra cardiac, and so compare them with cases which we have seen come to post-mortem. A diagnosis of aortic regurgitation in my clinic is no diagnosis at all, it is merely the detection of one of the signs of the disease affecting the heart, a sign common to several conditions. The same with a mitral lesion or a right venticular hypertrophy. The blood pressure, the history, the kidneys must all be taken into account.

After this preamble allow me to recite briefly a method which I have been trying out the last two years in an endeavor to get straight and permanent in the mind of the student the many complications of cardiac pathology and diagnosis.

From a study of the symptoms and signs in general and from the findings at post-mortem, we may divide diseased hearts into the following categories for teaching purposes:

Sclerotic hearts.
Rheumatic hearts.
Syphilitic hearts.
Nephritic hearts.
Infected hearts.
Degenerated hearts.
Displaced hearts.
Neurotic hearts.

1. Sclerotic hearts occur always in advanced life (note that we differentiate syphilitic hearts). The vascular system is effected in general. The blood pressure is high. The disease approaches the heart generally by the way of the aorta, therefore, the pathology is generally found in the neighborhood of the aorta, aortic valves and coronary arteries, and not so often in the mitral region; in rare instances, well defined pulmonary sclerosis is found. The physical signs and symptoms of this type of heart lesion are aortic regurgitation, aortic stenosis, sclerosis of the coronary arteries, sclerotic myocarditis, precordial distress and angina pectoris. Occasionally mitral stenosis.

2. Syphilitic hearts show a picture very similar to sclerotic hearts because the effect of syphilitic infection is to produce a profusion of fibrous tissue. We must, therefore, look to some place besides the heart for differential signs. Sclerotic change in people under middle age is almost always due to syphilis. We will find in this case:

Patient often under middle age.
Leutin or Wassermann reaction positive.
History of syphilis.
Blood pressure not necessarily raised.
Arteries not necessarily involved.
Mitral valve rarely affected.

*Read before The College Alliance, Chicago, Feb. 17, 1915.

3. Rheumatic hearts found in children and young people or in lesions dating from youth.

Generally history of rheumatism.

Blood pressure negative.

Arteries not involved.

Mitral valve usually affected.

Right ventricular hypertrophy.

Secondary or relative murmurs present late in the disease.

Impossible to differentiate from old streptococcus or gonorrhœal infections except by history and extra cardial symptoms.

4. Nephritic hearts. No murmrus until late in the disease when relative murmurs develop.

Left ventricular hypertrophy.

High blood pressure.

Characteristic urinary findings of nephritis.

Arteries sclerosed.

Little sclerosis of heart itself.

Few symptoms pointing to the heart until late.

Closely resembles other lesions in terminal stages.

5. Degenerated hearts.

Degeneration and weakening of heart muscle.

Palpitation and dyspnœa.

Either acute toxic hearts following infectious diseases or chronic degenerations, amyloid, fatty, etc.

Acute dilatation.

Cases known clinically as "cardiac insufficiency."

Low blood pressure.

Valvular lesions, if present, all relative.

Many extra cardial symptoms.

6. Displaced hearts. A heart may be normal and yet be displaced by some abnormal condition in the thorax or abdomen. An extra long thorax may make the heart appear displaced. Such cases offer difficulty to the student, especially if the displacement is not excessive.

This classification and the few distinguishing remarks are not intended to be final, complete and bullet proof. It is merely an outline for elementary teaching. Occasionally we have to make some exceptions to general rules laid down, but not as often as in the old way, which keeps a teacher constantly explaining and apologizing. It will cover very satisfactorily almost all cases of heart disease seen in the clinic as well as in the dead room. Uræmia, jaundice, tachycardia are losing any identity they may ever have had as distinct diseases, so with valvular leaks.

And now let us consider the subjects of hypertrophy and dilatation of the heart. These are generally grouped together in text-books and very little definite said about either one. The best students in the class will get these subjects so muddled in their minds that in a week after answering to a perfect quiz they will be entirely unable when confronted by a clinical case to make any adequate and logical explanation. Even the graduate doctors and the teachers must confess that these subjects are more or less muddled in their own minds. They will never be grasped by the student so that he can retain them until they are separated and reclassified.

Now let us plainly understand first of all that there are two distinct types of dilatation. The neglect to impress this very point on the student is one of the principal causes of the muddling. These two types are a primary dilatation, coming as a first effect in a diseased condition, and a secondary type, coming late in heart disease, as the hypertrophied heart gradually weakens and the muscle wall gives way.

This primary or early dilatation comes most often from one of the following three things: (a) Prolonged exertion, running, foot ball, etc. (b) Sudden strain on a toxic or degenerated heart. (c) As the very first effect of a valvular leak. The sequence is also three-fold. It is either immediately corrected on rest; ends in sudden death, or hypertrophy gradually follows.

To make things more tangible, I put the following outline on the board:

PRIMARY CARDIAC DILATATION.

1. Physiological—following extreme exertion, running, etc.

2. Sudden violent strain on a weakened or degenerated heart muscle.

3. Toxic heart muscle. So-called acute dilatation of infectious diseases.

4. Constant over filling of chambers. First effects of valvular leaks.

5. Terminal dilatation—found post-mortem in some non-cardiac diseases.

SECONDARY CARDIAC DILATATION.

1. Following any hypertrophy, either primary or secondary, when the heart muscle begins to fail and death is not far off unless vigorous treatment is instituted.

Hypertrophy is also of two types, primary and secondary.

PRIMARY CARDIAC HYPERTROPHY.

1. Increased arterial tension.

Nephritis.

Arteriosclerosis.

Prolonged muscular exertion—labor.

2. Precardial adhesions.

3. Slow increase in systolic work.

Slight aortic leak.

Obstruction in circulation, cirrhosis of liver, etc.

Gradually developing pulmonary resistance.

4. Long continued stimulation, coffee, tobacco, etc., tachycardia, Graves' disease. Let it not be forgotten that a sclerotic myocardium will give the appearance of a hypertrophy on post-mortem when there is no absolute increase in the muscle.

SECONDARY CARDIAC HYPERTROPHY.

1. All valvular leaks.

2. Obstructive lesions in the lung.

3. Training of athletes.

The comprehension of heart lesions is bad enough at best; let us hope that we may succeed

in devising ways which will enable us to reason out these things rather than to merely remember them.

TYPHOID ANTITOXIN

BY H. M. STEVENSON, M. D., BALTIMORE, MD.

TO the present we have but few reports concerning the use of typhoid antitoxin. While the prophylactic serum, the vaccine, has been used far and wide during nearly two decades and its results have been analyzed exhaustively and reported upon, employment of the therapeutic preparations has been much restricted and the literature regarding this subject is meagre. Much of the data that is available comes from the hospital wards and, as conditions there are peculiarly unfavorable (under present circumstances) to its success, the reports from that source have rather discouraged its employment.

Typhoid antitoxin, as employed at present, produces the best results when used early in the case or before the disease has progressed far. As a rule, typhoid cases come late to the hospital wards for treatment, or from surroundings which permit rapid progress in a short time. Therefore, upon these cases wherein the disease is profoundly established, the dose of antitoxin thus far employed shows little or no beneficial effect. So as most new means of treatment are, to a great extent, made known through the hospitals, and as the peculiar circumstances have been a handicap to its success in those institutions, the use of this measure has not spread as it otherwise would have done.

But it is very possible that when experience warrants the use of much larger doses, initial and subsequent, the late and otherwise difficult cases will be benefited. Diphtheria antitoxin passed through a similar experience in regard to the evolution of its dosage. We recall that during the outbreak of this disease in a penal institution of this city some years ago, the prophylactic dose given to those exposed was five hundred units, while the maximum therapeutic dose was but 1,500 units. With every injection, too, one-thirtieth grain of Strychnia sulphate was given for temporary support to the heart during the time when as supposed that organ was depressed by the antitoxin. It may be mentioned that in all but seven cases of the disease developed in this crowded institution containing seven hundred prisoners. Today, however, the result would be regarded more as a matter of good luck rather than one of effective prevention, since now much larger doses, prophylactic and therapeutic, are considered necessary.

In private practice, each physician, as a rule, has under his care during the season but a few cases of typhoid fever and, therefore, but a limited opportunity for observing the effect of any treatment. But if those who use the antitoxin will make report, we may soon have available data necessary to place this valuable measure upon the more certain basis which it merits.

The charts herewith are selected from a moderate number of cases treated during the past few years. No attempt will be made to give exhaustive details. This is a field report and includes no fine analysis, but simply the larger details, the high lights which would impress the physician in connection with the diagnosis, the indications for treatment and the results. The main fact is that the fever existed, and after injection of the antitoxin the fever declined as shown. No spectacular abortion of the fever resulted, but it is safe to assume that in distinction from cases wherein the antitoxin was not employed the course of the fever was shortened, with an absence or mitigation in proportion, of the various effects of sustained high temperature. Over and again the treatment has been given during the past four seasons and over and again the results have been obtained, with such certainty that we give it in every case and would be much surprised if it failed in effect.

A concentrated solution of dead bacteria in serum, a sero-bacterin, is employed for the direct effect of the organisms in their antitoxic sphere and indirectly by their promoting the formation of antibodies in the patient's blood. But much has likely yet to be learned concerning their method of action and when this becomes known it is probable that the size of the dose and indications for its repetition will be better understood.

The first case is of a boy twelve years of age. He was on a farm for two weeks prior to his illness, drinking water from a spring, which, on the average farm, is an active focus for infection, situated, as it usually is, low in the valley, while high on the hilltop above is the outhouse, which drains readily into and pollutes the water supply.

The temperature in this case, as is usual with children, rose rapidly. There was general aching and languor and the tongue was furred. On the fourth day a Diazzo reaction appeared in the urine and on the seventh day a positive Widal reaction was, at the bedside, observed in the blood. These symptoms and circumstances, it may be mentioned, compose the average early clinical picture in typhoid fever. In some cases petechia appear early; more often not. With many the spleen is not palpable until later. So, historic incidents, more or less important, the foregoing symptoms, with a Diazzo reaction at the 4th or 5th day and a Widal in the 6th to 8th, together with exclusion of certain other possible conditions, form the basis for diagnosis. This mention is made of the diagnostic details for the reason that under the influence of the antitoxin many of the subsequent

classic conditions are absent or much modified.

On the seventh day, in this case, with a temperature of 104, a dose of 125 million dead bacteria was given hypodermically. Within nineteen hours following, the temperature dropped to 99 3-5. The drop was sudden and symptoms similar to those of the crisis in pneumonia occurred. General weakness, a clammy sweat and a quickened pulse rate were observed. These symptoms were but moderate and subsided with little or no treatment. By the next afternoon the temperature rose to 101, three degrees less than the previous maximum. From this point it gradually subsided and eleven days later it was normal throughout the twenty-four hours. The duration of fever in this case was, including an approximated period prior to the first observation, sixteen days in all.

The next case is of an adult, a male. The symptoms were similar to those of the foregoing case. On the second day under observation a positive Diazzo was noted and on the fourth day a positive Widal. On this day, with the temperature at 103 4-5, a dose of 250 million was given. Within seventeen hours the temperature dropped to 100 2-5 and, after rising to 101, it was in another 24 hours at 100 even. The next day it arose to 102 and this maximum was maintained for three successive days, on the last day going one-fifth higher. On this day a double dose, 500 million, were injected. In 14 hours the temperature dropped to 99 2-5 and in another 12 hours it dropped to normal. Twenty-four hours later the temperature was at 101, which was on October 13. From this point it gradually went down, and eight days later was normal throughout the 24 hours, making, in all, about 21 days of fever, including an approximated period of fever before the first observation.

The next chart is of an adult male, treated recently. This patient was under treatment for another condition when the typhoid supervened, hence the latter was under observation from the first day of increased temperature.

The early symptoms were, as usual, together, with a gradually ascending temperature, a positive Diazzo reaction on the 5th day and a positive Widal on the 8th. In this case petechia appeared early and were abundant.

On the eighth day, at completion of the diagnosis and with a temperature of 104 2-5, an injection of 250 million was given. Following this, for three days in succession, the temperature continued to drop until 99 2-5 was reached. At that time a second dose was given, this time 500 million. For three days again the temperature showed the effects of the treatment, and again reaching 99 2-5. Following this the temperature rose to 102 2-5 and then came down by lysis, reaching normal in ten days. The duration of fever in this case was 23 days.

The last case is of a child thirteen years of age. Fever had existed for four or five days when observed and a diagnosis was made at once. A different plan was employed in this case, small doses being given at rather short intervals. Four doses of 50 million were given in all. The behavior of the temperature following each dose is shown on the chart. Each small dose appeared to bring the temperature down, but it soon rose again, until the fourth dose was given, though altogether but 200 million were administered.

In none of these cases is there a period of continued high temperature. Although the temperature in many cases rises again and requires one or more additional doses, it has always dropped after administering the antitoxin. Moreover, in all of the cases the period of fever is reduced some 10 to 14 days from an average of thirty-one days.

The remaining treatment in these cases was very simple recumbent position, liquid diet, water, 40 to 50 ounces daily for the adult, a hot sponge bath morning and evening, good ventilation and few visitors, is about all included in the orders. Of medicines, Belladonna or Bryonia at one time or another composed the list of medicines.

HEADACHE.

BY A. H. DUNTON, M. D., CINCINNATI, OHIO.

IT is well when a patient presents himself for treatment to try at once to make a clear and concise diagnosis. This should be attempted at all times. I find, however, that this is sometimes an impossibility. There are many cases that have gone the rounds of many doctors with a persistent headache of obscure origin, usually giving this history:

A headache existing from one to twenty years with nothing done for it except an occasional dose of a palliative and never a thought of a diagnosis. I wish to recite, however, a case in my own experience which had gone the rounds of the best men, all trying, striving their best for a diagnosis, but none, including myself, arrived at anything definite, and yet the case was cured. This case only illustrates the wonderful power of our remedies when applied correctly to the case. The fact that I was unable to arrive at any single diagnosis makes no difference to the one that has to stand the suffering. It makes a good deal of difference to us who are able to arrive at a diagnosis, and keeps us trying to uncover a possible cause.

Patient M., age 27, female: occupation none, as she had never been without a headache. Family history: Father died at age of 67 of heart disease. Mother died at age of 54 of Bright's disease. Four sisters living and well She is the youngest of ten children.

Past History of Patient.—Had the ordinary diseases of childhood and of adult life. She had tonsillitis about two years ago. Had malaria at seven and at sixteen. Had tuberculosis four years ago, the right apex of the right lung being affected. She was cured completely of this by sanatorium treatment. Menstruation at sixteen normal.

In her family history there is nothing special of importance nor in her past history, as her headache started before she had any of the diseases mentioned.

Present Condition.—The patient, from her earliest recollections, was always with a constant headache. At approximately five years of age she was exposed to the heat of the sun, and was told in after life that she had sunstroke at that time. Her earliest memories, she tells me, were of pain in the head, and her people tell her that it did not start until after she was exposed to sunstroke. This headache had continued so long that she had become accustomed to the sharp, shooting pains that she first experienced, and at the time I saw her the headache was a constant dull headache. There was a dull, darting pain on stooping, worse in the morning, worse on sudden noise, and when rising the headache was worse for about an hour, then better. As a rule, worse in the morning, worse on motion and in a close room. Better on motion in the open air; somewhat relieved by cold; made worse by heat, but the relief was only slight in either case. The only thing that relieved her to any degree was heavy pressure at the bridge of the nose.

Location of the Dull Headache.—Principally at the bridge of the nose and over the eyes and on the top of the head; no vomiting; pain is shifting in character, sometimes settles in the back of the neck. About seven years ago a bed toppled over and fell on the head, and only since then the top of the head started to ache. Prior to this the ache being only at the bridge of the nose.

Eyes.—Fairly clear, pupils dilated; reaction normal.

This is the dull headache of which she complained, and which lasted for a period of approximately *twenty-two years*. She, however, had in addition to the dull headache a sick headache.

Sick Headache.—It comes on every two weeks or months, sometimes comes on once a week, but the average is once or twice a month. Since the dull headache has become so painful, the sick headache comes on less often, but during the attack the dull headache is worse.

Location.—Headaches all over. The head is sore to the touch on the temples, but not on the rest of the head. She describes it as a splitting headache, so painful in character that she could not even raise her head from the pillow. She is much better on going to bed, and if she does not go to bed everything gets black before her eyes. Formerly she used to see specks floating before her eyes, black in character, but not recently has this symptom occurred. During the attack she cannot even keep water on her stomach. She vomits every five or ten minutes a white, frothy mucus; better only by lying flat on her back. This lasts one or two days. During the attack and for a day after she cannot eat. This headache is better many times at 5 P. M. and as the sun goes down.

Special Symptom.—She lately sees a green halo around a light or any gas or street light, but she never notices it when tired.

Examination.—I took her to our friend, Dr. Ralph Reed, who made a very careful and thorough neurological study of the case. He reported to me negative findings from his study. Her eyes had been refracted by very good men and complete correction was obtained. Her nose has been operated on by a nose specialist of Minneapolis two years ago, but no relief followed, and the nose was in perfect condition.

Head.—Natural shape; no deformatives.

Throat.—Normal.

Heart and Lungs.—O. K. Breath sounds normal.

Stomach.—O. K., except at time of headache.

Bowels.—Normal; color natural. Not constipated.

Urine.—Normal.

Blood Pressure.—Systolic; 125 Wassermann; negative.

Dystolic.—100.

Diagnosis.—Headache of unknown origin.

Treatment.—I had made a week's careful study of this case and gone through every test that seemed called for, and yet I had not arrived at any conclusion; any one thing to point my finger to as a distinct cause.

In looking over my remedies, however, and in curing the case my hopes were raised immensely when I looked over the symptoms of Aconite, Belladonna and Glonoine. The dull headache, which she complained of, was not the throbbing headache that ordinarily goes with Glonoine, but I felt that she had this headache so many years that anyone in her condition, for such a period of time, would perhaps call it a dull headache and not a throbbing headache. The special symptom that she noticed a halo of light around electric light is one of the special symptoms under Glonoine. The history of the case, that of the headache coming on after sunstroke, is typical of Glonoine. The remedy was given in 6x potency for a period of six months, and the headache, that is a dull headache, disappeared entirely with the exception of occasionally slight return, only to be relieved by more 6x Glonoine. I disregarded at that time the sick headache, and when she came back to the city again I went over her case, and prescribed for the sick headache.

At this time I put her on Kali muriaticum 6x for her tissue remedy, thinking, perhaps, that it might change the chemical condition of the blood if a pathological condition existed, and from the fact of the vomiting symptoms. An intercurrent dose of Kali phosphorica 6x, occasionally, was also given. These tablets were given three times a day with a rest of a week, and Lloyd's Iris, 60 drops to four oz. of water, every hour during the attack. When the pain was real severe Magnesia phosphorica 6x, three tablets every ten to fifteen minutes in hot water (very small in amount), were given.

One year from the date of the first visit the patient had accepted a position as matron of a girls' home in Wisconsin, and she writes me that the headaches have totally disappeared, now a period of nearly a year's time.

I feel tempted many times to write a paper on various mistakes men have made in diagnosis, and shall include my own mistakes, as we learn most by our mistakes and remember it the longest. This headache, according to her statement, had been mistaken from gumma of the brain, as she told me several doctors had put her on some colorless medicine, starting with ten drop doses always increased, and which always made her worse. This was one mistake that had been made. The eye specialist told her that it was her eyes that caused all the trouble, but the proper fitting of glasses brought no relief.

The nose specialist had told her that she would be cured by an operation, and still no relief had come. Various other men had told her various other things, but after all it took one thing which so many of us never consider, "the indicated remedy," to find the cause of the condition, go to its location, and cure the trouble.

Cameron.

H. has examined 254 patients for the complement-binding reaction of whom 37 were known to have *malignant tumor*. Thirty-one per cent. or 84 per cent. of the latter gave a positive reaction Six of the 10 suspected carcinoma cases were positive, while most of those without malignant tumor were negative. One hundred and fifty-five cases were tested for the meiostagmin reaction, and 11 gave a positive meiostagmin reaction, and 11 gave a positive complement-binding reaction. H. concludes both methods are useful even if not absolutely specific, the complement-binding being more specific than the meiostagmin.—*Lydia M. DeWitt.*

Analyses of Hungarian *tobacco* before and after keeping six months and one year are presented. Most of the tobaccos lost a small part of their nicotine on keeping in a dry place.—*Wm. P. Garrety.*

REMEDIES THAT HAVE STOOD THE TEST.

BY DOUGLASS CALKINS, M. D., SUMMIT HILL, TENN.

AMONG the long list of medicines that have occupied the lime light in the years that are gone, many have been discarded, others have fallen short of their promise, and but comparatively few are now fairly established upon the substantial basis of time and experience. While the long tide has ebbed and flowed, the followers of the Hahnemannian law have, more or less consistently, hewn to the line, and occupied the success of abiding faith and systematic endeavor. Upon the basic law of Similars they have built the superstructure of therapeutics, and brought healing to suffering humanity. To each of us, according to his lights and his opportunities, have come his inspirations and revelations. I shall tell you, in this paper, of the impression made upon me of a few remedies, with the hope that it may prove of interest to you and, possibly, of profit.

The first medicine on my list is one that stands very high in my estimation, Gelsemium semper. After nearly thirty years of practice I am firmly convinced that this remedy has the power of aborting fevers of the remittent type, including typhoid. Not in all cases, but in a fairly large proportion if given early, in one drop doses of the tincture, you will save your patient from weeks of suffering and from the danger of death.

Arsenicum alb. is the next on my list, with special reference to its anti-neuralgiac quality. Case after case of facial neuralgia has promptly succumbed to its influence, after days of pain and a long succession of coal tar dopes, self administered. I may mention here that I always use it in conjunction with Cinchona because of its synergical action with that remedy.

The third and last medicine on my list is not, so far as I know, homœopathic in its action. It is, more or less, highly effective. I refer to the use of Carbonate of Creosote.

In broncho-pneumonia its effect is almost as potent as the antitoxine treatment in diphtheria. Given in two drop doses every two hours, it acts marvellously in reducing temperature, strengthening the heart and, in short, changing a desperate condition into a convalescence.

These are some of the remedies that have stood the test in the crucible of last resort,—bedside experience. That is my only excuse for placing this paper before you for your consideration.

Pituitary Diseases.

Dunn cites evidence from observation and experiment that proves the association of diabetes insipidus with pituitary disease. (Arthur D. Dunn.)

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AN APPEAL FOR AID.

IT is with pleasure that we publish the following letter from Dr. Burford and such an appeal from Dr. Burford must not be made in vain to American Homœopathy. Here is a chance, as the doctor points out, for a noble work for humanity and at the same time for Homœopathy. The editors representing the committee, will be glad to receive contributions for this work and forward the same promptly to Dr. Burford.

Editors MEDICAL CENTURY.

I have the pleasure to inform you that the Homœopathic Hospital for the treatment of the Sick, in contradistinction to the Wounded, from the fighting forces has been established at Neuilly, near Paris, under the aegis of the London Homœopathic Hospital; *i. e.,* this Hospital, founded at the initiative of the International Homœopathic Council, is administered through the organization of the London Homœopathic Hospital—the machinery of this Institution is utilized for the administration of the new Hospital in France—in order to avail ourselves of its experience. But the French Hospital is quite independent in point of maintenance of the London Homœopathic Hospital, and appeals to the whole world for personal and financial support.

This French Hospital is peculiar in being—so far as we are aware—the first Military Hospital in this war devoted solely to the interests of the sick. It is also peculiar in that it is the only Hospital that is Homœopathic throughout, staffed by Homœopathic doctors, its statistics available for Homœopathic publication, and last, but not least, officially recognized by the French Red Cross authorities as a *bona fide* Homœopathic Hospital.

Various among our Homœopathic colleagues in this country have thrown up their practices and have gone to serve in the War as independent medical units; of course they carry their Homœopathic personalities with them, but unfortunately these are lost in the midst of the vastly preponderant Allopathic fraternity with which they have to work, so their professional successes do not count for Homœopathy, they are unable to practice Homœopathy in an open and declared fashion, and the Institutions in which they work are very far from being declared Homœopathic clinics.

Our new Hospital, established after much care and trouble, and after conference with some of the highest State authorities, is most fortunately on the positive side with regard to the above-mentioned points. We hope to achieve, during the continuance of the war, an immense amount of good for the sick who come under our Homœopathic treatment, and for Homœopathy by the publication of our statistics at the termination of militarism in Europe.

I enclose some literature from which you will see that this Institution has the public support of the combined Homœopathic bodies in Great Britain, but it is not enough. We want to plant it on a larger basis, and my object in writing to you is to take a necessary step in inviting the enthusiastic support of our friends in America whose names stand for Homœopathy the world over. Our Institution in Paris takes in the sick from the fighting lines irrespective of nation or language. It is comparatively near the scene of action, so that considerable distances by land or water have not to be traversed by those to whose recovery every hour is of importance. It is organized and administered in a way to obviate the expenditure of one Penny in extravagance. Its Homœopathic conduct rests in the hands of its Subscribers, who, as Homœopaths, control and are responsible for its conduct and well-being.

Now, may I ask, in the name of the Committee, would you be so kind as to give this project due publicity in your Journal? Will You seize the moment for converging toward the French Homœopathic Hospital that financial aid from ardent Homœopaths which would otherwise be spent in more generalized areas? Will you

yourself, as representing the Committee, act as Treasurer for all Donations that may be sent through the instrumentality of your Journal for the Neuilly Homœopathic Hospital? You could thus extend a powerful humanitarian aid to the lives and health of sick soldiers who otherwise would miss the succor of Homœopathic practice. And you would be largely contributing to that statistical proof of the values of Homœopathy in time of War, which hitherto is lacking in our best literature.

Believe me, with kind regards,

Yours very faithfully,

GEORGE BURFORD.

A FEDERAL LICENSE BILL.

THE Harrison law comes to us under the guise of a license and tax law. Medical practitioners come within its provisions. We are required to fill out a blank stating that we are engaged in the practice of medicine and to pay a tax, and for this we get a sort of license and registry number.

We are then able to dispense the articles covered by the law, namely, opium and its compounds, and coca and its compounds and derivatives. And as the power given us is by the Government, it would seem that we can exercise this power in any state of the union we may happen to be in. If such right interferes with the state laws, or, if the exercise of this right interferes with some state law which says this is practicing medicine according to its definition, then so much the worse for the state law.

If we do not register or comply with the regulations we are fined and imprisoned. If we do comply with the regulations and some state political medical board insists by so doing that we are practicing medicine and arrests us, because we have a license in some other state only, what is to pay?

It would seem as though the Federal Government, by licensing us and taxing us, agrees that we have a right to practice medicine in any state of the union, and that if we are qualified in one state to practice and to be licensed and taxed we are so qualified in all states—and this is as it should be. If I possess sufficient skill to treat a disease in Michigan, and the Michigan board certifies thereto by granting me a license, I am certainly qualified to cross the line into Ohio and practice my profession without having to pay license of $50.00 to enable the Ohio board to pursue its functions.

We hope the Harrison law may be made a wedge for universal reciprocity.

A HOMŒOPATHIC "SPECTATOR."

FORTY-THREE years ago this month there was held in the city of Boston a fair for the benefit of the Massachusetts Homœopathic Hospital. In connection with this fair there was issued a daily record in the form of a periodical which is probably to-day one of the publications of our school of medcine that is exceedingly scarce. Those who have the ten numbers issued are indeed fortunate, for they possess not only an interesting but also a rare bit of American literature.

The periodical was entitled *The Pellet. To be taken every day.* Its senior editor was Mr. Thomas Bailey Aldrich, and the opening editorial is written in the charming and witty epigrammatic style of the famous author of "From Ponkapoag to Pesth" and "A Bad Boy." Among other things he says: "We avail ourselves of this opportunity to thank the various writers who have so generously responded to our call for literary contributions. To give from the superfluity of one's purse is good; but to give in that coin which, when genuine, is produced only by the most exhausting toil is the finest sort of charity."

That Mr. Aldrich was successful in securing literary contributions of genuine coin, the following review will show: The first number contains an article by Elizabeth Stuart Phelps, the gifted author of "The Gates Ajar," entitled "A Homœopathic Conversazione." A witty conversation with a physician on the subject of a homœopathic college in Boston which should admit women. The doctor's reply, after feeling her pulse, that she was suffering mentally and needed treatment is charmingly caricatured. On page 7 is an interesting statement and translation on the early use of anæsthesia contributed by Henry W. Longfellow. It was from the Sieur De Bartus, poet, Huguenot, and captain in the army of Henry of Navarre, who was born in 1544 and died in 1590 from wounds received at the battle of Ivry. The subject of the poem was "The Creation of Eve."

Edmund C. Stedman also contributed a poem to this number.

The second number has column and a half

storiette by W. Dean Howels. Editor Aldrich says that Howells was engaged upon another work of fiction which he tried to secure for serial publication in *The Pellet,* but the *Atlantic Monthly* outbid him. Howells was at that time editor of the *Atlantic Monthly,* his successor being Aldrich himself.

In the third number Mr. Aldrich says: "*The Pellet* resembles Boccacio's *Decamerone* in this respect,—it is only a ten days' entertainment." In the fourth number is a sonnet by Bayard Taylor, who writes that in sending the verses for our "infinitesimal 30th potency paper" he is helping a creed in which he does not believe; but that a "hospital covers all creeds." Aldrich has this to say of Mr. Taylor: "Our friend's tolerance and charity lead us to think that he must, at heart, be a true homœopathist;" and again, "It is only here and there that one meets with a man who would fry a brother for a slight difference of opinion."

George S. Hilliard, orator, polished writer and brilliant essayist, author of Hilliard's Readers, was a frequent contributor, both in poetry and prose.

Louise May Alcott, of "Little Men and Women" fame, contributed a short poem, entitled "To a Good Physician From a Grateful Patient."

Wendell Phillips, the famous orator and abolitionist, not only repeated his lecture, "The Lost Arts," for the benefit of the hospital, but also wrote a squib for *The Pellet.*

E. P. Whipple, critic and essayist, author of "Recollections of Eminent Men," was likewise a contributor,

Lydia Maria Child, one of the famous group of abolitionists, which includes Phillips, Lowell, Garrison and Theodore Parker; the author of an early New England romance, entitled "Hobomok," was a contributor to this now famous daily.

James Freeman Clarke, abolitionist, transcendentalist, author of "Ten Great Religions;" James T. Fields, editor of the *Atlantic Monthly,* in its famous days of the sixties, writer of "Yesterdays With Authors;" John Neal, author of "Keep Cool" and the "Wandering Recollections of a Somewhat Busy Life;" John Weiss, religious and political writer, a contributor to the *Atlantic Monthly* and *Our Young Folks;* Charles C. Perkins, of "Tuscan Sculptors" fame; Kate Hillard, an *Atlantic Monthly* writer; Professor Sewall, Lucy A. Williams, Annie Moore, Celia Burleigh, were all represented by original contributions.

Besides these were rare and valuable selections, some of which were printed for the first time in America, all scintillating with wit.

What periodical of ten brief issues of twelve pages each can boast of such an array of literary talent, and the articles presented were the genuine coin, fresh from the mint. Even the story told by Aldrich of how Bret Harte decided the California symbol on the cover of the *Overland Monthly* was from a private letter received from Mark Twain and here published for the first time.

The editorial pages were filled with bright items. It was perhaps a bit of presumption but the welcoming by the little *Pellet* of that "greatest of all pellets," the Boston *Daily Globe,* which had just issued its first number, to the field of American journalism, makes delightful reading.

The concluding issue in which the *Pellet* makes its bow is full of editorial cheerfulness.

Thus:

"If the *Pellet* could have its way—but it is too modest and practical to dream of so high an honor—it would be billeted among the garrulous *Tattlers,* the observant *Spectators* and the conscientious *Guardians* of the past."

Then he speaks of the "phantom voice" of the *Pellet,* addressing the spirit of the press as follows:

"If you please, sir, I am a little paper that died the other day. * * *

"I have noticed everybody favorably; and though the partisan of a creed that has sometimes been unjustly used, I have been neither dogmatic nor abusive, but have endeavored to be cheery and entertaining and sweet tempered, so that even allopaths might not find me a bitter pellet to take. * * *

"If you please, sir, though I lived to be only ten days old, I appear before you not as a failure, but as a success."

It is doubtful whether all the literati of the "Cheshire Cheese," "The Spectator," "The Tattler," "The Guardian," or any group of the famous *Atlantic Monthly* coterie ever produced in ten issues an amount of literary matter more readable or better displayed.

The fair was a great success, financially and socially. It marked an epoch in the history of the Massachusetts Homœopathic Hospital. It

was attended each day by the best of Boston—even New England. We note in the fair items printed in the *Pellet* that Longfellow, Phillips and John Greenleaf Whittier and many others of fame were visitors. It is quite possible that one small man of the *Atlantic Monthly* set had some of his "Delusions" desystematized by learning of the success of the fair. He was not a contributor to the *Pellet* nor do we note that he was a visitor, but Editor Aldrich included a delightful "selection" from the "Autocrat of the Breakfast Table," which served a real homœopathic purpose.

MICHIGAN HEALTH BULLETIN.

THE State Board of Health publishes a monthly magazine called *Public Health*.

It contains, among other pertinent or impertinent health data, a flowery description of Justice Brook administering the oath of office to the newly elected state officials.

There is also a ladies' literary club paper, and a "New Year's Story," by the secretary of the board, and an unsigned poem called "Good By to the Old Year: Welcome to the New."

It would seem as if Michigan could find a better place to spend her money than to permit such tommyrot to be published in its health bulletin.

PHARMACODYNAMICS AND THERAPEUTICS.

ALBERT E. HINSDALE, A. B., M. D., COLUMBUS, O.

(The material for this issue has been abstracted and arranged by Mr. J. R. Shoemaker, of Ohio State University.)

Corpus Luteum.

From the corpus luteum of a cow a lipoid was isolated, which is insoluble in alcohol, but soluble in ether and free from cholosterol. It is called lutecolipoid, and it shortens the coagulation time of the blood in animals. By its injection excessive menstrual bleeding can be controlled. A second substance, a lechithalbumina, is called lipamin, was also isolated. In the rabbit it lengthens the coagulation time of the blood. On repeated injections the uterus and ovaries of the rabbits increase in size and become hyperæmic and soft. Cases of amenorrhea were treated successfully. The menstruation did not occur immediately after the injection. The corpus luteum thus formed contains more lipamin and the ripe one more lipoids. These substances are credited with important functions with regard to menstruation. (Chemical Abstracts.)

Caffeine.

Caffeine and its citrate were administered in doses averaging 0.7 of a grain per day. In myocardinal insufficiency with retained body fluids Caffeine causes, (1) A moderate increase in the excretion of urine with a proportional loss in body weight; this increase reaches its maximum on the fourth day. (2) A drop in both systolic and diastolic blood pressure. (3) A slight temporary raise in pulse rate, but no permanent change in either the pulse or respiratory rate. (4) A moderate relief of the cardiac symptoms. (5) The constant appearance of distressing nervous and gastric symptoms. The clinical diuretic action of Caffeine may be better performed by large doses of Theobromine sodium salicylate.—*I. Greenwald.*

Intestinal Obstruction.

The power of the liver to pair camphor and grycurosis acid appears to be seriously impaired after duodenal obstruction, and the decrease in the water contents of the tissues is about 10 per cent. the same as after salivation by pilocarpine for four days or fasting for seven. The toxemia of duodenal obstruction arises from an interference with the cellular reaction of the intestinal epithelium. When small intestinal epithelial cells were placed in the stomach of duodenally obstructed animals such animals lived nearly twice as long as controls. This evidence is opposed to the bacterial theory of the origin of toximies. (John W. Draper, New York.)

X-Ray.

Mammals that are exposed to the action of Roentgen rays to a period of four days after birth become backward in growth. The young born of these animals remain undeveloped and these in turn bore offspring which were undersized. The third generation remained sterile. Frequent pregnancies did not occur with the animals of any generation and the mature animals were smaller with each generation. Cystic degeneration was present in the ovaries of the first mother and this was the final cause of sterility. (Mansfield Franklin, of Berlin.)

Morphine.

Subcutaneous injections of a fourth to a sixth grain of Morphine into the dog resulted in a disturbance of tonus, amplitude, and rhyth of the intestinal movements lasting often for twenty-four hours. During the first four hours following the injection there was a diminution in the production of substances stimulating peristalsis, also a less vigorous reaction to the peristalsis stimulating substances of a normal intestine. For the next twenty hours all production of the excretory substances ceased, and the intestine did not react at all to the excretory substances formed. At the end of twenty-four hours the intestine again regained its normal state.—*H. B. Lewis.*

Acids.

Using a method of successive intestinal fistulas Milovosorov confirmed the work of Boldyrev and finds that the farther from the pylorus the intestinal contents are removed the lower the acidity of the stomach contents. The passage of 200 c.c. of 0.5 per cent. hydrochloric acid solution from the stomach into the intestine is accompanied by a very gradual decline in the chlorine contents of the stomach, and a rise in the chlorine contents of the intestine proportional to the decline in the stomach. This would indicate that the neutralization of the gastric contents by those of the intestine takes place.

Camphor.

We think the following conclusions are justified: (1) Strychnine:—No action on the respiratory centre or circulation, possibly increase in metabolism. (2) Caffeine:—Stimulation of the respiratory center, moderate increase in metabolism, no effect on circulation. (3) Atropine:—Marked increase in the metabolism, in large doses it will cause classical action on the circulation. (4) Camphor:—The result not agreeing, no conclusions are ustifiable.—*J. H. Means.*

Diphtheria.

In 84 per cent. of mothers and children normal antitoxin is found in the serum of both, coming from the mother through the placenta. Forty-seven and five-tenths per cent. of all mothers give intra-cutaneous reactions with diphtheria toxine, although their blood contains normal toxine. Negative toxine reaction in adults shows positive presence of diphtheria toxine in the blood. (Chemical Abstracts.)

Drinks.

Contrary to the generally held and often expressed opinion that pure fruit juice beverages cannot be prepared commercially without the use of preservatives, the author has found drinks of this character on the market that are pure and free from all forms of preservatives. (W. Rossce, Philadelphia.)

Ozone.

A test was made of the Ann Arbor water plant in 1910 and was found that the system, as installed, was a failure, as far as bacterial efficiency was concerned, due mainly to the intermittent action of the aspirators which caused a poor mixture of the ozone and water.—*S. P. Powell.*

Lactose.

Increasing amounts of sugar do not affect the absorption of fats up to a certain point beyond which absorption may be diminished. Excessive amounts of sugar may result in increasing the acidity of the stools in diarrhœa. (F. B. Talbott, Boston.)

Tuberculosis.

The findings of Deycke and Much, who obtained, in guinea pigs, an immunity with tubercle bacillus-lecithin emulsion against tuberculosis were not confirmed. The best results show only a partial immunity in a few cases and complete in none.

Pregnancy.

A negative result of Abderhalden's reaction speaks strongly against pregnancy. But a positive reaction may be also due to such causes as sarcoma or purulent processes.

Arsenic.

Arsenic promotes the formation of fat and develops the bones in normal animals that are well nourished. (A. Van den Eckhout, Ghent.)

BOOK REVIEWS.

THE TWELVE TISSUE REMEDIES OF SCHUESSLER. Comprising the Theory, Therapeutic Application, Materia Medica, and a Complete Repertory of These Remedies, Homœopathically and Bio-Chemically Considered. By William Boericke, M. D., and Willis A. Dewey, M. D. Fifth Edition. Rewritten and Enlarged. 450 Pages. Cloth, $2.50, net. Philadelphia. Boericke & Tafel. 1914.

This is the fifth edition of this well known and very popular book. It has been rewritten and enlarged and now has 450 pages.

Much of the research investigation of the past ten years has been made along the lines of Biochemistry. Especially has there been studied the various salts, which are component parts of the human body. All this which has not heretofore appeared in this volume has been incorporated.

Further, the extensive use of these remedies, chemically, has produced the widening of their usefulness and many new cases have been incorporated in the clinical part. The extensive demand for this work is gratifying to the authors and the publishers. Its sale has been and is phenomenal. It is a book that goes not only to physicians of the Homœopathic school, but to physicians of all schools.

ŒDEMA AND NEPHRITIS. A Critical, Experimental and Clinical Study of the Physiology and Pathology of Water Absorption in the Living Organism. By Martin H. Fisher, M. D. Second and Enlarged Edition. New York. John Wiley & Sons, Inc. 1915.

This is the second edition of Dr. Fisher's work on Œdema and Nephritis. It is a combination of the 1909 Nathan Lewis Hatfield Prize Essay of the College of Physicians of Philadelphia and the 1911 Cartwright Prize Essay of the

Alumni of the College of Physicians and Surgeons of Columbia University, New York, previously published as separate volumes bearing the titles "Œdema" and "Nephritis." The close association between the two made their appearance in combined form seem advisable.

The subjects have been gone into exhaustively and there is, perhaps, no other work ever published that is as thorough and exhaustive as this one. It is a very well printed volume with numerous illustrations, and contains practically all that is known to the present time about these conditions.

It is certainly a book that the general practitioner will profit by procuring and studying. For anyone that deals with kidney infection is not only of interest, but of importance to the practice of medicine. The closing chapter is devoted to Glaucoma, which sheds considerable light upon this infection.

NEWS ITEMS.

ILLINOIS.

The State Homœopathic Medical Society of Illinois is not to surrender its annual meeting in favor of the Institute, but will hold the same at its usual time in May. The headquarters of the society, as is customary, will be at the Sherman House. Here, certainly, members of the homœopathic profession will feel at home, for, as we have before stated, this hotel has become known as Homœopath headquarters in Chicago.

MICHIGAN.

The Homœopathic Medical Society of Western Michigan held its monthly meeting in Grand Rapids on March 17th. An interesting program was arranged. The drawing feature was Dr. A. L. Blackwood, of Chicago, who presented a paper on "The Clinical Features of Baryta mur." Dr. A. B. Grant, of Albion, Mich., was another speaker, whose paper was on "Vaccination by Internal Method." The meeting of the Society was followed by a banquet, which was well attended.

Dr. I. O. Deman, of Toledo, Ohio, presented a paper at the March meeting of the Practitioners' Society.

Dr. Martin Robinson, of Detroit, announces his marriage to Miss Charlotte Lebster. Congratulations.

NEW YORK.

Plans are being made for the Annual Alumni Meeting and Banquet of the New York Homœopathic Medical College and Hospital, which will occur in May. It is hoped to make this the best anniversary meeting the Institute has ever held.

PENNSYLVANIA.

The Homœopathic Medical Society of the County of Philadelphia held its regular monthly meeting at Hahnemann College, on Thursday evening, February 11, 1915, at 8:30 o'clock. The scientific program consisted of the following:

"A Straight Talk to Young People," O. S. Haines, M. D.

"Convincing Observations of Homœopathic Medicines," W. H. Yeager, M. D.

"Some Present Needs of Our Materia Medica," W. D. Griggs, M. D.

The meeting, which was an enthusiastic one, was largely attended and many important topics were discussed by those present.

W. M. Sylvis, M. D., *Secretary.*

The Philadelphia Society for Clinical Research held its regular monthly meeting at the office of Dr. E. G. Muhley, 1508 South Broad street, on Wednesday, February 24, 1915. Dr. Muhley read reports of two very interesting cases, which were as follows:

"Osteitis," discussion of which was opened by Drs. H. L. Northrop and G. Harlan Wells. "Bichloride Poisoning," discussion opened by Dr. Wm. A. Pearson. Both reports and discussions were thoroughly interesting and the meeting was an enjoyable one.

E. A. Steinhilber, M. D., *Secretary.*

The Clinico-Pathologic Society of Philadelphia held its regular monthly meeting at Hahnemann College, Saturday evening, February 20, 1915, at 8:30 o'clock. The scientific program consisted of the following:

"The Relation of Uterine Myomas to Pregnancy," with report of Illustrative Case, Dr. J. E. James.

"Unusual Types of Exophthalmic Goitre," Dr. W. D. Bayley.

"Mediastinal Tumors." Report of Two Cases, Dr. R. S. Leopold.

Several very interesting clinical cases were reported and discussed, after which Dr. W. C. Barker gave a lantern demonstration of X-Ray plates, which was thoroughly enjoyed by all present.

B. K. Fletcher, M. D., *Secretary.*

The Eye, Ear, Nose and Throat Society of Philadelphia held its regular monthly meeting at Hahnemann College, on Monday evening, February 8, 1915, at 7 P. M. The scientific program consisted of the following:

"A Dissection of the Brain," H. L. Northrop, M. D.

"A Refraction of School Children," L. C. Wessels, M. D.

There was a full attendance of members and keen interest was shown by those present.

J. F. V. Clay, M. D., *Secretary.*

The Oxford Medical Club of Philadelphia held its regular monthly meeting at the Hotel Walton. Dr. C. H. Brown read a paper, entitled "Remedial Measures Other Than Drugs," after which a hearty discussion took place. Many members were in attendance and the meeting was an enjoyable one.

E. M. Gramm, M. D., *Secretary.*

The Homœopathic Medical Society of the 23d Ward of Philadelphia held its regular monthly meeting at the Windsor Hotel, 1217 Filbert street, on Wednesday, February 17, 1915. Dr. E. Humphreys read a paper on "Glaucoma," which proved to be an inter-

esting feature of the occasion. The meeting was attended by a large number of members.

J. D. Boileau, M. D., *Secretary.*

The Homœopathic Medical Society of Chester, Delaware and Montgomery Counties held its regular monthly meeting at the Windsor Hotel, 1217 Filbert street, on Tuesday, February 9, 1915, at 1 P. M. "Abdominal Pain" was the title of a paper read by Dr. T. B. Bradley, and which was listened to intently by a large number of members present. Dr. T. L. Chase opened a discussion in which many members took part. A lunch was then served to all present, which was much enjoyed.

Isaac Crowthers, M. D., *Secretary.*

The Germantown Homœopathic Medical Society held its regular monthly meeting at the Majestic Hotel, Broad and Girard avenue, on Monday, the 15th of February, 1915, at nine o'clock in the evening. Dr. G. J. Alexander presented a well prepared paper on "Indications for the Acute Mastoid Operation" (for the general practitioner), which was a pleasing feature of the occasion. The Censors reported favorably the names of Dr. J. B. Bert and Dr. J. A. Brooks.

L. W. Thompson, M. D., *Secretary.*

The Homœopathic Medical Society of Delaware County held its regular monthly meeting in the staff-room of the J. Lewis Crozer Hospital, Chester, Pa., on Thursday, March 11, 1915, at 3 P. M. Dr. J. V. F. Clay, of Philadelphia, gave a talk on "Acute Otitis Media," which proved to be a very interesting feature of the occasion. The meeting was attended by a large number of members.

G. C. Webster, M. D., *Secretary.*

PERSONALS.

The Training School for Nurses of the West Philadelphia Homœopathic Hospital held its graduating exercises on Thursday evening, March 2, 1915, at eight o'clock, at the West Park Presbyterian church, 54th and Lansdowne avenue. The class was composed of many bright women who had completed their course in training.

Dr. C. A. Heritage announces the removal of his office to 324 Summit avenue, Jenkintown, Pa.

Dr. and Mrs. G. K. Krick, of Reading, Pa., announce the birth of a son, on March 1, 1915.

OBITUARY.

Dr. Walter Montgomery James, known among his associates in the medical profession as "The Ajax of Homœopathy," died of stomach trouble and complications at his office, 1231 Locust street, Philadelphia, Pa., on February 18, 1915.

Dr. James was born in Philadelphia, March 22, 1849. He attended a private school and then entered the Pennsylvania Homœopathic Medical College, which, later, merged into what is now Hahnemann College. He was graduated in 1869. For a time he was associated with Dr. Lippe, one of the pioneers in Homœopathy. In 1880 Dr. James founded the "Homœopathic Physicians' Journal," and edited it for many years.

Dr. James was a member of the Germantown Homœopathic Club, Oxford Club, Art Club, Historical Society, Penn Club, Franklin Institute and the American Historical Society.

OBITUARY.

Dr. N. L. Dow.

Glover, Vt., Dec. 1, 1914. Hahnemann Medical College, Chicago, 1887.

Dr. Adolphus E. Chamberlain.

Yuma, Mich., Jan. 9, æt. 56. Hahnemann Medical College, Chicago, 1881.

Dr. Joseph T. Cook.

Buffalo, Jan. 18, æt. 59. Homœopathic Hospital Cleveland, 1881.

Dr. John Borough.

Mishawaka, Ind., Dec. 31, 1914, æt. 71. Homœopathic Medical College, Cleveland, 1874.

Dr. Leonard W. Carpenter.

Trumansburg N. Y., Nov. 8, 1914, æt. 81. Homœopathic Hospital College, Cleveland, 1865.

Dr. W. M. Nead.

Albany, N. Y., Dec. 26, 1914, æt. 55. Homœopathic Hospital College, Cleveland, 1884.

Dr. H. F. Wegener.

Tacoma, Wash., Feb. 5, æt. 70. Hahnemann Medical College, Chicago, 1874. Since 1876, a high school teacher and principal.

Dr. C. H. Viehe.

Evansville, Ind., Feb. 1, æt. 78. Hahnemann Medical College of Mo., 1876.

Dr. William E. Walker.

W. Charleston, Maine, Jan. 1, æt. 50. Hahnemann Medical College of Philadelphia, 1891.

Dr. J. D. Wetmore.

Portland, Ore., æt. 50. Hahnemann Medical College, 1882.

Dr. J. H. Hoag.

Connersville, Ind., Jan. 24. Hahnemann Medical College, Chicago, 1883.

Dr. A. P. Sawyer.

Chicago, Feb. 3, æt. 59. Hahnemann Medical College, Chicago, 1880.

Dr. A. H. Pierce.

W. Newbury, Mass., Feb. 9, æt. 54. Boston University School of Medicine, 1882.

Dr. Charles L. Powers.

Coffeyville, Kan., Feb. 3, æt. 70. Hahnemann Medical College, Chicago, 1878.